

## 3 Nursing Services Guidelines

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## 3.1 Introduction

### 3.1.1 General Policy

This section covers all Medicaid services provided through Private Duty Nursing (EPSDT Program), Nursing Services DD & ISSH Waivers, and Supervising Registered Nurse (PCS Program). These specialties are identified as nursing services throughout this section.

Each section addresses the following:

- Prior authorization
- Covered services
- Provider qualifications
- Plan of care
- Physician's and nurse's responsibilities
- Record keeping
- Place of service codes
- Diagnosis codes (For EPSDT and PCS Oversight)
- Procedure codes
- Reimbursement

Providers of Nursing Services with the specialties of *DD/ISSH Waiver Services* and *Supervising Registered Nurse for the PCS program* can access program specific guidelines at the Medicaid website:

**[www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov)**.

**Note:** Private Duty Nursing, Nursing Services DD & ISSH Waivers and Supervising Registered Nurse (PCS) are covered for Medicaid **Enhanced Plan Benefits** participants.

### 3.1.2 Prior Authorization and Healthy Connections

Prior authorizations are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval. For Healthy Connections clients, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

If prior authorization is required, the prior authorization number must be indicated on the claim or the service will be denied,

**Note:** Nursing services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

**Note:** Nursing services are a covered benefit for Medicaid Enhanced Plan Benefits participants.

See **Section 2.3.2** for more information on billing services that require Prior Authorization.

## 3.2 Nursing Services Policy - Private Duty Nursing

### 3.2.1 Overview

Private Duty Nursing Services are limited to certain eligible children for whom the need for such service has been identified in an Early and Periodic Screening, Diagnoses, and Treatment (EPSDT) program screening. The medical needs of the child must be such that the Idaho Nursing Practices Act requires the services be provided by a licensed nurse.

**Note:** Private Duty Nursing services for participants enrolled in the Medicaid Basic Plan Benefits are limited to diagnostic and evaluation procedures only. Participants must be enrolled in the **Medicaid Enhanced Plan Benefits** in order to be eligible for additional nursing services.

**Note:**  
Nursing services are a covered benefit for Medicaid Enhanced Plan Benefits participants.

#### 3.2.1.1 Family Participation

The purpose of Nursing Services is to provide support and relief for the family of the effected child. Families are expected and encouraged to participate in the provision of care.

### 3.2.2 Provider Qualifications

All nursing providers must be currently licensed as either an RN or LPN in Idaho and have a signed provider agreement on file with Idaho Medicaid. Nursing service providers must provide documentation of current Idaho licensure as an RN or LPN.

#### 3.2.2.1 Independent Provider

An independent provider is an individual who provides nursing services as an independent contractor and has a signed provider agreement on file with Idaho Medicaid.

#### 3.2.2.2 Provider Agency

The provider agency is an entity that takes responsibility for the care given and provides payroll and benefits to those care providers it employs. The entity must have a signed provider agreement on file with Idaho Medicaid.

The provider agency must indicate on the claim if an RN or LPN provided the service delivery.

### 3.2.3 Covered Services

Private duty nursing services are limited to the following services. The services require oversight by a Registered Nurse (RN) if provided by a Licensed Practical Nurse (LPN):

- NG Tubes — Nasogastric (NG) tube coverage includes the insertion and maintenance of NG tubes and client feeding activities with or without the use of a feeding pump.
- Volume Ventilators — the maintenance of volume ventilators includes associated tracheotomy care when necessary.
- Tracheotomy and Oral/Pharyngeal Suctioning — Suctioning and cleansing of the client's airway and removal of excess secretions from the mouth, throat and trachea.
- IV Therapy/Parenteral Nutrition — Maintenance and monitoring of an IV site and administration of IV fluids and nutritional materials that requires extended time to administer.

### 3.2.3.1 Plan of Care

All services provided on an implementation plan are based on a written plan of care. The Supervisory RN is responsible for the plan of care, based on:

- The nurse's assessment and observation of the client
- The evaluation and orders of the client's physician
- Information elicited from the client

The plan of care must be approved and signed by the physician. It must also include all aspects of the medical, licensed, and personal care necessary to be performed, including the amount, type and frequency of such services.

### 3.2.3.2 Plan of Care Update

The plan of care must be revised and updated based on treatment result or the client's changing profile of needs as necessary, but at least annually. A copy of the plan of care must remain in the client's home.

Submit annual updates and changes to the plan of care to the Regional Medicaid Services (RMS) in the region in which the child lives. Refer to the Directory Section of this handbook for the correct regional address and phone number.

### 3.2.3.3 Prior Authorization of Services

The Regional Medicaid Services (RMS) must authorize all **private duty nursing (PDN)** services prior to service delivery. The authorization will indicate the hours of service per week for which the service is authorized.

If prior authorization is required, the prior authorization number must be included on the claim or the service will be denied.

### 3.2.3.4 Non-covered Services: Transportation

Medical transportation of the client, such as to the physician's office, is **not** a covered service under the private duty nursing program but may be covered under the Transportation section of Idaho Medicaid.

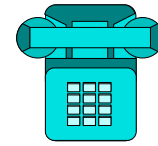
### 3.2.4 Nursing Oversight

Nursing oversight is the intermittent supervision of the child's medical condition for health status or medical services within the scope of the Nurse Practice Act and must be provided when an LPN is giving the care. Nurse oversight services must be provided by an RN licensed to practice in Idaho. The services are limited to one time per month. If additional oversight visits are medically necessary, prior authorization can be requested from the EPSDT Coordinator.

### 3.2.5 Nurse Responsibilities

The nurse's responsibilities are as follows:

- Immediately notify the physician of any significant changes in the client's physical condition or response to the service delivery.
- Evaluate changes of condition.
- Provide services in accordance with the plan of care.
- Maintain records of care given to include the date, time of start and end of service delivery, services provided, and comments on client's response to services delivered.



Contact the  
Medicaid  
Transportation  
Unit for  
transportation  
questions at:  
(800) 296-0509 or  
(208) 334-4990  
from the Boise  
calling area

- LPN providers must document oversight of services by an RN in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing.

### 3.2.6 Physician Responsibilities

All Private Duty Nursing services must be provided under the order of a licensed physician. The physician must:

- Provide Medicaid the necessary medical information to establish the client's medical eligibility for services based on an EPSDT Medical Screen
- Order all services to be delivered by the nursing provider
- Sign and date all orders and the client's plan of care
- Update client's plan of care annually and as changes are indicated, sign and record date of plan approval
- Determine if the combination of nursing services along with other community resources are no longer sufficient to ensure the health or safety of the client and recommend institutional placement of the client

**Note:**

If the child is enrolled in the Healthy Connections (HC) program, the order must be from the Healthy Connections Provider.

### 3.2.7 Reimbursement

#### 3.2.7.1 Overview

The nursing provider and, when necessary, the independent RN or agency providing oversight are paid a fee-for-service as established by Medicaid. Separate claims for payment must be submitted for each provider.

#### 3.2.7.2 Registered Nurse

An RN can provide either oversight of an LPN or direct care.

#### 3.2.7.3 Private Duty Nursing Provider

Payments are limited to the services specified on the plan of care on file with the Bureau of Care Management. The EPSDT Coordinator in the central office must approve all plans of care prior to any claim payment.

### 3.2.8 Record Keeping

Private duty nurses or nursing agencies maintain service records on each client receiving nursing services. The record will be maintained in the client's home. After every visit, the provider will enter, at a minimum, the following information:

- The date and time of visit in the following format:  
**Date example:** 02/10/2005  
**Time example:** 8:00 a.m. - 11:15 a.m.
- The length of visit in the following format:  
**Example:** 3 hours and 15 minutes would be 3.25 hours
- The services provided during the visit
- A statement of the client's response to the services including any changes noted in the client's condition
- Any changes in the plan of care authorized by the referring physician as a result of changes in the client's condition
- Signature and credentials of the individual providing services.

### **3.2.8.1 Transfer to Another Provider**

When the care of the client is transferred to another provider, all client records must be delivered to and held by the client's family until a replacement provider assumes the case. When the client leaves the program, the records are retained by Medicaid as part of the client's closed case record.

### **3.2.8.2 Change in Client Status**

It is the responsibility of the private duty nurse to notify the physician when there is a significant change in the client's condition. Physician notification must be documented in the service record.

### **3.2.9 Place of Service Codes**

Use only **one** of these two place of service codes to bill nursing services. Enter this information in field 24B on the paper claim form or in the appropriate field of the electronic claim:

**12** — Home

**99** — Other unlisted facility

The following places are **excluded** as personal residences:

- Licensed Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF)
- Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Licensed shelter homes
- Licensed professional foster homes
- Licensed hospital

**3.2.10 Procedure Codes**

All claims must use one of the following five-digit HCPCS procedure codes, and if appropriate the required modifier, when billing nursing services. Enter the HCPCS code in field 24D on the paper claim form or in the appropriate field of the electronic claim.

Service	State Code (Effective to 10/19/2003)	HCPCS Code (Effective 10/20/2003)	Description
Private Duty Nurse Agency RN	0527P	T1001 <b>TD</b> Modifier Required	Nursing Assessment/Evaluation Professional licensed nurse, registered nurse or RN employed by an agency 1 unit = 15 minutes
Private Duty Nurse Agency LPN	0528P	T1000	Private duty/independent nursing service(s) – licensed Agency LPN 1 unit = 15 minutes
Private Duty Nurse Individual RN	0529P	T1000	Private duty/independent nursing service(s) – licensed Individual RN 1 unit = 15 minutes
Private Duty Nurse Individual LPN	0530P	T1000 <b>TE</b> Modifier Required	Private duty/independent nursing service(s) –licensed Individual LPN 1 unit = 15 minutes
Professional Licensed Nurse Oversight	0531P	T1001	Nursing Assessment/Evaluation Professional licensed nurse oversight of a licensed practical nurse 1 unit = 1 assessment/evaluation
RN Services	0532P	T1002	RN Services Ventilator care by licensed nurse RN or LPN 1 unit = 15 minutes



### 3.3 Nursing Services Policy - DD & ISSH Waivers

#### 3.3.1 Overview

Nursing services include nurse oversight and skilled nursing services. All nurse oversight and skilled nursing services require prior authorization in accordance with IDAPA 16.03.13 "Prior Authorization for Behavioral Health Services." The authorization will indicate the hours of service per day and the number of days per week the service is authorized.

**Note:** Nursing services for participants enrolled in the Basic Plan are limited to diagnostic and evaluation procedures only. Participants must be enrolled in the **Medicaid Enhanced Plan Benefit** in order to be eligible for additional nursing services.

**Note:**  
Nursing services are a covered benefit for Medicaid Enhanced Plan Benefits participants.

#### 3.3.1.1 Nurse Oversight Services

Nursing oversight is the intermittent supervision of the client's medical condition, plan of care, for health status or medical services, which are within the scope of the Nurse Practice Act. Nursing oversight includes the supervision of delegated nursing services provided by the Residential Habilitation provider or other Medicaid providers. Nurse oversight services must be provided by a registered nurse (RN) licensed to practice in Idaho.

#### 3.3.1.2 Skilled Nursing Services

Skilled nursing services include the provision of hands-on nursing services or treatments to eligible participants who need skilled nursing services. The medical needs of the participant must be of such a technical nature that the Idaho Nursing Practices Act requires the services to be provided by a licensed nurse.

Skilled nursing services require oversight by a registered nurse (RN) if provided by a licensed practical nurse (LPN). Skilled nursing services are limited to the following:

- **NG Tubes** — NG tubes include the insertion and maintenance of NG tubes and consumer feeding activities with or without the use of a feeding pump. A registered nurse or licensed practical nurse must perform this service.
- **Volume Ventilators** — The maintenance of volume ventilators includes associated tracheotomy care when necessary. A registered nurse or licensed practical nurse must perform this service.
- **Tracheotomy and Oral/Pharyngeal Suctioning** — Sterile suctioning and cleansing of the consumer's airway and removal of excess secretions from the mouth, throat and trachea. Only a registered nurse may perform this service.
- **IV Therapy/Parenteral Nutrition** — Maintenance and monitoring of an IV site and administration of IV fluids and nutritional materials, which require extended time periods to administer. A registered nurse or licensed practical nurse must perform this service.

**Note:** To perform services effectively, nursing services providers should be aware of program requirements for other providers in the DD waiver program. See Section 3 of the *Idaho Medicaid Provider Handbook for Home and Community Based Waiver Services for Clients with Developmental Disabilities*.

### **3.3.2 Provider Qualifications**

Nursing service providers must provide documentation of current Idaho licensure as an RN or LPN. Only an RN may provide nurse oversight. Nursing service providers must have a signed provider agreement on file with the Idaho Medicaid Program.

### **3.3.3 Plan of Care**

All nurse oversight and skilled nursing services provided must be on a plan of care based on an Individual Support Plan (ISP). The RN is responsible for the plan of care based upon:

- The nurse's assessment and observation of the client
- The orders of the client's physician
- The ISP
- Information elicited from the client

The plan of care must include all aspects of the medical care, licensed and non-licensed necessary to be performed, including the amount, type and frequency of such services. When care is delegated to a non-licensed Residential Habilitation provider, type and amount of supervision and training to be provided must be included in the plan.

#### **3.3.3.1 Plan of Care Update**

The plan of care must be revised and updated based upon treatment result or the client's changing profile of needs as necessary, but at least annually. The plan of care must be submitted to the Department or its designee for review and prior authorization of service. A copy of the plan of care must remain in the client's home.

### **3.3.4 Nurse Responsibilities**

- Notify the physician and service coordinator immediately of any significant changes in the client's physical condition or response to the service delivery.
- Evaluate changes of condition.
- Provide services in accordance with the implementation plan and the ISP.
- Maintain records of care given to include the date, time of start and end of service delivery, and comments on client's response to services delivered.

In the case of licensed practical nurse (LPN) skilled nursing providers, and other non-licensed direct care providers, document that oversight of services by an RN is in accordance with the Idaho Nurse Practice Act and the Rules, Regulations, and Policies of the Idaho Board of Nursing. An RN can provide either oversight or direct skilled nursing services.

### 3.3.5 Record Keeping

Service records will be maintained on each client receiving nursing services. The record will be maintained in the client's home. After every visit the provider will enter, at a minimum:

- The date and time of visit in the following format:  
**Date example:** 02/10/2005  
**Time example:** 8:00 a.m. - 11:15 a.m.
- The length of visit in the following format:  
**Example:** 3 hours and 15 minutes would be 3.25 hours
- The services, supervised or skilled observation, provided during the visit
- A statement of the client's response to the services including any changes noted in the client's condition
- Any changes in the ISP plan of care authorized by the ISP as a result of changes in the client's condition
- Signature of the individual providing services, including their professional designation

### 3.3.6 Place of Service Codes

Nurse oversight and skilled duty nursing services can only be billed for the following places of service:

**12** — Client's home

**99** — Other unlisted facility

The following places are **excluded** as personal residences:

- Licensed Skilled Nursing Facilities (SNF) or Intermediate Care Facilities (ICF)
- Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Licensed shelter homes
- Licensed professional foster homes
- Licensed hospital

Enter this information in field 24B on the paper claim form or in the appropriate field of the electronic claim.

### 3.3.7 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing nurse oversight and skilled nursing services.

Service	State Code	HCPCS Code	Description
Nursing Oversight Independent RN Visit	0140B	T1001 <b>U8, TD</b> Modifiers Required	Nursing Assessment/Evaluation 1 unit = 1 assessment/evaluation
Nursing Oversight Agency RN Visit	0150B	T1001 <b>U8, TD</b> Modifiers Required	Nursing Assessment /Evaluation 1 unit = 1 assessment/evaluation

Service	State Code	HCPSC Code	Description
Independent (Skilled LPN) Hourly	0170B	T1000 <b>U8</b> Modifier Required	Private Duty/Independent Nursing Services - Licensed 1 unit = 15 minutes
Agency (Skilled LPN) Hourly	0180B	T1000 <b>U8, TE</b> Modifier Required	Private Duty/Independent Nursing Services – Licensed 1 unit = 15 minutes
Agency ( Skilled RN) Hourly	0190B	T1000 <b>U8, TD</b> Modifier Required	Private Duty Nursing/Independent Nursing Services – Licensed Minimum age is 21. 1 unit = 15 minutes
Oversight of LPN Visits (RN Skilled)	0200B	T1001 <b>U8</b> Modifier Required	Nursing Assessment/Evaluation 1 unit = 1 assessment/evaluation.

### 3.4 Nursing Services Policy - Supervising RN (PCS)

#### 3.4.1 Overview

Nursing services under the Personal Care Services (PCS) program has the responsibility for supervising the delivery of personal care services to the PCS participant. Nursing services under the PCS program does **not** include hands-on care. A registered nurse who is functioning as a personal assistant may **not** provide Supervisory RN services to the same participant. Supervising RN (PCS) services must be authorized by Regional Medicaid Services.

**Note:** Nursing services for participants enrolled in the **Medicaid Basic Plan Benefits** are limited to diagnostic and evaluation procedures only. Participants must be enrolled in the **Medicaid Enhanced Plan Benefits** in order to be eligible for additional nursing services.

**Note:**  
Nursing services are a covered benefit for Medicaid Enhanced Plan Benefits participants.

#### 3.4.2 Record Keeping

Service records will be maintained on each participant receiving nursing services. The record will be maintained in the participant's home. After every visit the provider will enter, at a minimum:

- The date and time of visit in the following format:  
**Date example:** 02/10/2005  
**Time example:** 8:00 a.m. - 11:15 a.m.
- The length of visit in the following format:  
**Example:** 3 hours and 15 minutes would be 3.25 hours
- The services, supervised or skilled observation, provided during the visit
- A statement of the participant's response to the services including any changes noted in the participant's condition
- Any changes needed in the plan of care as a result of changes in the participant's condition
- Signature of the individual providing services

#### 3.4.3 Provider Qualifications

Nursing service providers in the PCS program must provide documentation of current Idaho licensure as an RN. Nursing service providers must have a signed provider agreement on file with the Idaho Medicaid Program.

#### 3.4.4 Plan of Care

The Supervising RN is responsible for the development of the Plan of Care based upon:

- The nurse's assessment and observation of the participant
- The orders of the participant's physician
- Information elicited from the participant
- Information from the Qualified Mental Retardation Professional (QMRP) if the individual is developmentally disabled.

The plan of care must include all aspects of the medical care, licensed and non-licensed necessary to be performed, including the amount, type and frequency of such services. When care is delegated to a personal assistant, the type, amount of supervision, and amount of training to be provided must be included in the plan.

### 3.4.5 Plan of Care Update

The plan of care must be revised and updated based upon treatment result or the participant's changing profile of needs as necessary, but at least annually. A copy of the plan of care must remain in the participant's home.

### 3.4.6 Nurse Responsibilities

- Develop the plan of care for the PCS participant
- Notify the physician, RMS, and case manager (if needed) immediately of any significant changes in the participant's physical condition or response to the service delivery.
- Supervise the treatment given by the personal assistant by reviewing the participant's PCS record maintained by the personal assistant, talking to the participant and/or the participant's family, and observing the personal assistant performing delegated tasks.
- Conduct on-site reviews with the participant at least every 90 days or as specified in the plan of care.
- Evaluate changes of condition when requested by the personal assistant, case manager or participant through on-site visits.
- Update the plan of care as necessary, and at least annually.
- Re-evaluate the plan of care as necessary

### 3.4.7 Diagnosis Code

Enter the ICD-9-CM code **V604 — No Other Household Member Able to Render Care**, for the primary diagnosis in field 21 on the paper claim form or appropriate field on electronic claims.

### 3.4.8 Place of Service Codes

PCS services including those of the Supervising RN may only be provided in a participant's personal residence unless the RMS authorizes the services to be provided in the provider's home.

Use place of service code **12** to indicate the client's home or **99** to indicate other place of service as appropriate for the place of service on the claim. Enter this information in field 24B on the paper claim form or in the appropriate field of the electronic claim.

The following are specifically excluded as personal residences:

- Licensed skilled nursing facilities (SNFs), intermediate care facilities (ICFs), or hospitals
- Licensed intermediate care facilities for the mentally retarded (ICF/MR)
- Licensed residential care facilities
- Licensed Level III or professional child foster homes
- Licensed adult foster homes

### 3.4.9 Procedure Codes

All claims must use one of the following five-digit HCPCS procedure codes when billing PCS Supervisory RN nursing services.

Service	State Code (Effective to 10/19/2003)	HCPCS Code (Effective 10/20/2003)	Description
Supervisory RN Codes Participant Evaluation and Plan of Care Development (Agency)	0501P	G9002	Coordinated Care Fee, Maintenance Rate 1 unit = 1 visit  Each time this procedure code is used it must be prior authorized by Regional Medicaid Services (RMS). The Medicaid office will assign a prior authorization number that must be on the claim form submitted to EDS for payment. This code is to be used for the initial visit and annually for the re-evaluation. If additional evaluations are necessary, obtain prior authorization from the RMS.  The RMS authorizes the number of PCS hours after the Uniform Assessment Instrument (UAI) is completed. The RN does the plan of care based on hours from the UAI.
Supervising Visit (Agency)	0503P	T1001	Nursing Assessment/Evaluation 1 unit = 1 visit  The frequency of the supervising visits must be included in RMS approved Functional Assessment/Plan of Care but no less than every 90 days. If additional or emergency visits in excess of the approved number are required, they must be prior authorized by the RMS and the PA number must be indicated on the claim.

## 3.5 Claim Billing

### 3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

### 3.5.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

#### 3.5.2.1 Guidelines for Electronic Claims

##### Detail lines

Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

##### Referral number

A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

##### Prior authorization (PA) numbers

Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

##### Modifiers

Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

##### Diagnosis codes

Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

##### Electronic crossovers

Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

See **Section 2** for more information on electronic billing.

### 3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original red CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

#### 3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.



- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

### 3.5.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS  
P.O. Box 23  
Boise, ID 83707

### 3.5.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required, required if applicable, desired, and not required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable.	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable.	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable.	Required if field 11d is marked YES.

Field	Field Name	Use	Directions
9d	Insurance Plan Name or Program Name	Required if applicable.	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable.	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable.  This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). <b>Example:</b> November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.

Field	Field Name	Use	Directions
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an <b>X</b> .
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

## 3.5.3.4 Sample Claim Form

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM										PICA			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										PICA <input type="checkbox"/>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. INSURED'S POLICY OR FECA NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY		13. EMPLOYER'S NAME OR SCHOOL NAME	
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										18. I.D. NUMBER OF REFERRING PHYSICIAN		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										21. MEDICAID RESUBMISSION CODE		22. PRIOR AUTHORIZATION NUMBER	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____										24. DATE(S) OF SERVICE From MM DD YY To MM DD YY		25. PLACE OF SERVICE Type of Service	
26. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER										27. DIAGNOSIS CODE		28. \$ CHARGES	
29. DAYS EPSDT OR Family Plan										30. EMG		31. COB	
32. RESERVED FOR LOCAL USE										33. RESERVED FOR LOCAL USE		34. RESERVED FOR LOCAL USE	
35. FEDERAL TAX I.D. NUMBER SSN EIN										36. PATIENT'S ACCOUNT NO.		37. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
38. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)										39. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		40. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
SIGNED DATE										PIN#		GRP#	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)  
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)  
FORM OWCP-1500 FORM RRB-1500